Arlington Board of Health

M
S

Seasonal Flu and Pneumonia Vaccination
2014-2015 Insurance Information Form

Information about the person receiving the vaccine (please print): *Required Fields

Name: (Last, First, MI)*	Date of Birth: *	Age*	Sex: (Circle)*
	_____ _____ _____ Month Day Year		Male Female
Street Address:*			
City:*	State: *	Zip:*	Phone:* ( )

Insurance Information: *Include the whole member ID number and any letters that are part of that number*

Name of Insurance Company:*	Member ID Number:*	Group ID Number: (if available)
Name of Secondary Insurance	Member ID Number:*	Group ID Number: (if available)

If person receiving vaccine is not the subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)*	Subscriber's Date of Birth: *	Sex: (Circle)*
	_____ _____ _____ Month Day Year	Male Female
Subscriber's Street Address:* (If different from address above)		
City:*	State:* ☐	Zip: *	Phone:* ( )
Patient Relationship to Subscriber: (circle)* Spouse Child Other:_____			

For children 18 years of age and younger:

- ☐ Is enrolled in Medicaid (includes MassHealth, HMOs etc. if enrolled through Medicaid)
- ☐ Does not have health insurance
- ☐ Is American Indian (Native American) or Alaska Native
- ☐ Has health insurance and is not American Indian (Native American) or Alaska Native

I give permission for myself (or my child) to receive the vaccine, for vaccination information to be included in the Massachusetts Immunization Information System (MIIS)* and for my insurance company to be billed. **Please see reverse side for MIIS details.*

X _____ Date: _____
(Signature of patient, parent or legal guardian)

For Clinic/Office Use Only:

Vax Type	Vax Mfgr	Lot No	Exp Date	Dose (mL)	State Supplied	Preserv Free	Injection Route (Circle)	Injection Site (Circle)	Date On VIS	Date VIS Given 2014
☐ IIV3				0.5	Yes No	Yes No	IM	R Arm L Arm	8/19/14	
☐ IIV4				0.5	Yes No	Yes No	IM	R Arm L Arm	8/19/14	
☐ LAIV4	Medimmune			0.20	Yes No	Yes	Intranasal	NA	8/19/14	
PPV23	Merck			0.5	Yes	No	IM	R Arm L Arm	10/06/09	

Clinic Site Name/Address: Arlington Board of Health, 27 Maple Street, Arlington, MA 02476

MDPH Provider PIN#: 11828 **Vaccine Administrator Initials**: _____ **Date of Service**: _____/2014___

Please Turn Page

Arlington Board of Health

M
S

Seasonal Flu and Pneumonia Vaccination
2014-2015 Insurance Information Form

The following questions will determine if you (or your child) can receive the 2014-2015 Seasonal Flu Vaccine. Please mark YES or NO for each question.

A. If you answer "YES" to one or more of the four questions, you (or your child) will <u>not</u> be able to receive the flu vaccine. If you answer "NO" to the following questions you (or your child) will receive the vaccine unless a concern arises following additional screening. If you are not sure of the answers to these questions, please check with your healthcare provider.

Information about the person receiving the vaccine	**YES**	**NO**
1. Do you have a serious allergy to eggs?	↑	↑
2. Do you have a serious allergy to gentamicin, neomycin, polymixin or gelatin?	↑	↑
3. Have you ever had a serious reaction to a previous dose of flu vaccine?	↑	↑
4. Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	↑	↑

B. Your answers to the following questions help us determine which vaccine is best for you (or your child).

☐

Information about the person receiving the vaccine	**YES**	**NO**
1. Do you have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?	↑	↑
2. If your child is 2-4 years of age, has a healthcare provider told you that your child had wheezing or asthma within the last 12 months?	↑	↑
3. Are you on long-term aspirin or aspirin-containing therapy (for example, do you take aspirin every day)?	↑	↑
4. Do you have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	↑	↑
5. Are you pregnant?	↑	↑
6. Do you have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	↑	↑
7. Are you currently taking anti-viral therapy (e.g., Tamiflu, Relenza, etc.)?		

Please be sure to complete all of the information on the <u>front side</u> of this form. Thank you.

*Providers are required by law to report your immunizations to the Massachusetts Immunization Information System (MIIS) (M.G.L c.111, Section 24M). For more information, please visit the MIIS website at www.mass.gov/dph/miis, or contact the Massachusetts Immunization Program directly at 617-983-6800 or 888-658-2850.

Please inform us if you have a latex allergy.